

wanted it to go.

The thing that was frustrating is that there were lawyers, lawyers, lawyers, lawyers. And there was nobody from public health. And when they sat around the table and discussed things, it was lawyers there discussing with other lawyers in reference to their clients; their clients were the tobacco companies, their clients were other people in society, their clients were the attorneys-general who got their own lawyers from outside their offices, and we had just one person representing our side. Now, he is a very zealous and a very efficient guy, Matt Myers, who now runs the campaign for Tobacco-Free Kids. But I do think if he had said --

INTERVIEWER: "Our side" in this case? You said Matt Myers was representing our side.

DR. KOOP: He was the person that was opposed to smoking and opposed to the tobacco industry's influence on children, advertising and everything else.

INTERVIEWER: But that was different than the attorneys-general?

DR. KOOP: He had a passion that was closer

to --

INTERVIEWER: He was a pure advocate.

DR. KOOP: He was a pure advocate, but I think he should have protected himself by saying, "I want seven people from public health on this committee to be my advisers and to work with me." And a lot of us tried to talk with him, and I was talking to both sides, back and forth, all the time, and the settlement itself was a tremendous thing, huge amount of money, over 25 years, but it were the things that happened apart from that that made me leave Washington and move up here.

And when Trent Lott behaved the way he did and said that this subject will not come up again as long as I am president of the Senate, and when we took a vote in the Senate and won, and we discarded the vote. It just seemed to be such highhanded --

INTERVIEWER: He discarded the vote? Explain more, because I'm not familiar with this.

DR. KOOP: I don't understand it either. But the Senate vote was in favor of tobacco -- well, let me interrupt and say that an ad hoc committee of Senators and Congressmen asked me if I would be co-chair of a

committee, and David Kessler would be my other co-chair, and that we would prepare, with the help of anybody we wanted to get, the gold standard for tobacco legislation, to control tobacco in the United States. And I think it's one of the better things that we did, and we presented that gold standard. And essentially, that gold standard was sort of what we were voting on, although it wasn't in the words that we used, and my recollection is that we had six more votes than we needed, and essentially won that battle, and then Trent Lott said that he was withdrawing the, what I would think would be a completed act, he was withdrawing it from the Senate and -- .

This was an interesting time, because we had some stalwarts from both sides of the aisle in both Houses of Congress who were really hopeful -- Ted Kennedy being one of them -- that we would finally come to something that would pin the ears of the tobacco industry back where they belonged. And when all those things happened, in a matter of a couple of days, I said, "If working as hard as I can with a very efficient volunteer group helping me, and with the reputation that

I have in Washington about tobacco and about integrity, if working two years like this, it comes to nothing more than we have seen, there's no point in my staying here."

So I left and came here.

INTERVIEWER: And this would have been legislation that would have been far more regulatory and far more --

DR. KOOP: Yeah.

INTERVIEWER: -- and would have controlled the tobacco industry and tobacco sales and advertising?

DR. KOOP: But you remember -- yeah, but you remember, it was a little more complicated than that, because there actually was a court case that came up in the south that we lost, in trying to assure the role of the FDA in the regulation of tobacco. So it wasn't as open and shut as I like to think it was. It's a funny way to say it, but there were so many things going on at the same time, that I think even legislators were confused.

INTERVIEWER: And the settlement was a separate track.

DR. KOOP: Separate, indeed.

INTERVIEWER: And when that came down and was finally legislated and accepted, were you satisfied with that? Were you satisfied --

DR. KOOP: No, I was not satisfied with it because although the sum of money was exorbitant and I think fitting and proper, the thing that bothered me was that there were so many little things that were just ignored, and when the questions came up about them, the answers were all, "Well, we understood that that was to be this way," you know. They pretty well ran roughshod over things that weren't settled by individual articles in the law.

INTERVIEWER: The size of the settlement. Do you recall what that was?

DR. KOOP: The what?

INTERVIEWER: The size of the settlement?

DR. KOOP: 270 billion, I think.

INTERVIEWER: Over 25 years? And since that time there has, of course, been highly variable use of the money on a state-by-state basis. Your thoughts about that?

DR. KOOP: Only one state has used the money

for its intended purpose completely, and that's Mississippi. And that's because Michael Moore was one of the major protagonists in the group of attorneys-general who were bringing the suit. But --

INTERVIEWER: And that purpose was tobacco reduction?

DR. KOOP: There were two major issues. One was to prevent children from starting to smoke, and the other was to make treatment available and worthwhile for adults. So (inaudible) still a problem.

INTERVIEWER: But other than that, states have used it in a variety of ways?

DR. KOOP: Well, it came at a difficult time when, because of an awful lot of problems in the economic world, practically every state in the union was running a deficit budget. And they saw this as sort of having won the lottery. And nobody had any qualms about taking that money and using it to fill potholes or fix bridges or pay schoolteachers or maternal and child health, or -- very, very little of the money went to health, even if it was tobacco health.

And states like California and Massachusetts,

which had the best programs for their own citizens, the money that was available was in such short supply that they lost a lot of their people, a lot of their programs. New Hampshire, exactly the same way.

Everything up here was jeopardized. I knew 24 people that were very active in the state, working with us here periodically, and they all were without funds all of a sudden because the money was not used for its intended purpose.

INTERVIEWER: What will happen to tobacco in America? What's your prognostication? Will we better the situation now in terms of percent of the population?

Well, it's down, it's 20-some-odd --

DR. KOOP: Five.

INTERVIEWER: Twenty-five percent?

DR. KOOP: I think -- I don't think you can talk about the United States separately. The United States is 9 percent of the global economics of tobacco.

And to make that payment of \$200-and-some billion, and other things that have happened, and no one knows what's going to happen with the huge suit that's been brought by the government against the tobacco industry, but

that's a lot bigger than the settlement is, if they were to win that, and it means that there's going to have to be some very innovative financing, and I don't see the one thing that could be a deterrent, and that is a global public health effort to fight big tobacco.

INTERVIEWER: It's not there.

DR. KOOP: It's not there. And the thing is, you can't expect Zimbabwe to fight it by itself, or the Philippines to fight it by itself. The American Cancer Society has done as much as anybody, by bringing over to this country selected individuals from developing nations to teach them how we have handled the politics of big tobacco, and to teach them the ways that we have used our political muscle, the way we've used public education, the way we've used gimmicks here and there. And it just -- it's a nice effort, and it's well thought out and very well-meaning, but it's just too little recognize \_\_\_\_\_ size of the problem.

INTERVIEWER: So I gather from that you think that the United States' efforts over reduction will remain where they are, but a great deal of the commercial and promotional effort's been moved globally?



And will remain so?

DR. KOOP: I think so. And you know, again it fits into -- it's a politically bad time to worry about tobacco, when you try to get the attention of a concerned citizen who is worrying about the war in Iraq, the economics at home, and people dying tobacco deaths in Indonesia, you know what takes third place. And I don't know any way to overcome that.

Everybody talks about the shrinking globe and the fact that our problems are everybody else's problems, and there's no such thing as a disease which is somebody else's problem alone, and yet we're not doing the things that should come from that understanding and working together to try to fight what's happening.

When you think about the fact that 500 million people now alive and well on this planet will be dead by 2025, you know, I can't take that number in. I tried to work it out. That's the same number of deaths as if you had all the Vietnam War deaths every day for 25 years. It's the same as if the Bhopal incident in India recurred every four hours for 25 years. It's the

Titanic sinking every 47 minutes for 25 years. If you wanted to build a Vietnam-type memorial to these people that were going to die by 2025, you'd use the same kind of set-up. It would start in Washington and go westward over six countries, and end in Kansas City. A pretty big monument.

INTERVIEWER: Well, I think that puts tobacco in perspective.

Would you like to take a break and --

DR. KOOP: I'll walk about a bit.

(Recording interruption.)

INTERVIEWER: I'd like to pick up with looking at public health in America. We can talk global later, but talking United States in particular. Post-9/11? I mean, that certainly was a seminal event for the nation, but also for public health. It's not clear to me whether it started public health on a new route and, of course, 9/11 is overlaid with anthrax and events of that period. Do you -- I mean, how do you feel about the direction of public health? Do you think it's gotten new life? Or do you think it's been diverted into wacky bioterror concerns?

DR. KOOP: I think that public health in the United States began to slip in the Clinton administration, and I think that we began to lose some of the people in the commission corps that I thought were real stalwarts and people who understood the permanence of such a group and what its contribution could be to the nation. And since that time, everything that I have seen or been able to understand that was happening to the public health service of the United States in that group, and especially to the commission corps, has been downhill.

And I actually got to the point where I stopped going to meetings of the commission officers that were social events and I sometimes could attend, just because I'd come home so depressed by everybody's cornering me and telling me how awful things were and how they were going downhill and getting worse. And I think that a lot of little things -- there were some changes in pay for -- of the uniformed services, but they weren't passed on to the public health service, and at every turn it seemed that something was happening that wasn't good, and then when I was asked to testify

about the public health service and about the commission corps before Shays' committee, I really felt that the public health service and the commission corps were being exposed to scrutiny from people who really didn't understand much about either, and when you got finished hearing all the complaints it sounded like things just couldn't be very good in the future.

INTERVIEWER: This Representative Shays -- Chris Shays?

DR. KOOP: Chris Shays.

INTERVIEWER: Of Connecticut.

DR. KOOP: Bioterrorism didn't start with 9/11, and we've had ample discussions about bioterrorism in the confines of the public health service and in the commission corps, and it seems to me that we never took very much of an effort to do anything about it, and yet I believe that the public health service, as it was constituted when I was there, and the commission corps particularly, was very well suited to running a program that would be as good as you would expect.

You can't prevent terrorism, and so your effort has to be on ready response. And rapid

deployment of your resources to prevent things from going from bad to worse. And I don't see that.

And I think the manner in which the anthrax, for example, was handled was five cases -- suppose it had been 50? Suppose it had been 5,000? Suppose it had been 50,000? I mean, what would we have done? I think we wouldn't be over the panic yet.

And I don't know enough about the new department except that it's the biggest we have to have in government --

INTERVIEWER: Homeland Security?

DR. KOOP: Homeland Security, to know how well that's going to go. I think Governor Ridge was given a very tough assignment, because, I mean, people such as you and I know that Washington and your ability to function there depends an awful lot on old-boy networks and people you know and can call on in time of need, and Ridge came into Washington with a huge task to perform, and no connections at all. And I think that with that in mind, he has done an admirable job with what he had to face. But as far as being able to show me or anybody else, "This is what we would do if somebody blew up this

bridge and attacked us at the same time," and so and so forth, and that's what worries me.

INTERVIEWER: In the real 9/11 and the post-9/11 period there was a lot of money put into the system in and around public health, including very specific and rather wooden items, like vaccine procurement. I don't mean that disrespectfully, but "wooden" in the sense you've bought that, that's just a flat purchase starter pile. Do you get any sense that this new money, new attention, has invigorated American public health in general \_\_\_\_\_ public health service, or not?

DR. KOOP: If you ask me a yes or no question, I'd say not. And I realize that in organizations such as the size of which we're talking, a lot of things can be good that are going on that you don't hear about, but you hear about the bad things. And I don't want to badmouth the official representatives of public health in this country. But I do have the feeling that the people who know the most, those who are responsible -- not medically, but line officers for the defense of this country -- are as concerned as I am about the lack of

preparedness, and that worries me. It worries me at the level of communication. And it seems to me that the public health service, going back to the NIMNIS (phonetic) days, has had --

INTERVIEWER: "NIMNIS"?

DR. KOOP: You must know what --

INTERVIEWER: Shame on me.

DR. KOOP: It's the thing that -- about 1986 or so, the military made a decision that they would not try to have a chain of health command like they had in the Korean War, with MASH units and base hospitals and up, but that the transportation was sufficiently good for the entire globe that we'd have the hospitals here, use the benching(?) system, and transport our wounded to there. And there were a lot of people who had -- public health service who had obligations to NIMNIS, and some were people who would be called up immediately if there were a military conflict and so on. And the only reason I raise it is that the thing that always appealed to me about NIMNIS, it was a system that was working in a time of peace, in a civilian authority, but it was transferable to a military need just by saying, "Hey,

we're using you."

And we have a group up here that's working on some of the problems with terrorism, that's an official DARPA thing, and then there's another group of us that have published five papers on terrorism so far, all asking the same thing: that in this day and age, terrorism is going to best be fought in cyberspace because we have a communications system, and if we're going to use our heads we want a system when we finish using it for the military, we can use it for civilians, and it works just as well.

And whatever we have should be able to handle the Oklahoma bombing of a government building or a tornado or hurricane or a flooding, as well as it could handle anthrax in Trenton or with the post office. And that's what we've been trying to focus our attention on is a system that is not either military or civilian, but it can serve both at any time by a switch of the --.

And I know that's not answering your question, because it's very hard to get your hand on what's going on, and I would be hard put to make you a list of the things that ought to be changed right now.



INTERVIEWER: Yeah. I don't have a sense that, say, the profession of public health has received a bump up in public esteem. I don't have a sense that more physicians are choosing public health or public health careers. I don't have a sense -- I know actually I'm not as well read on this, that might be admitted, but post-9/11 CDC published an evaluation of state health capabilities, connectivity being a big one, that was just an embarrassment.

DR. KOOP: Right.

INTERVIEWER: I mean --

DR. KOOP: Well, that's what I mean about it's got to be fought in cyberspace. The number of local first responders that don't even have a computer and can't go on the Internet, can't send e-mail -- it's astonishing, really.

And the other thing that you mentioned, I don't find people dedicated to public health as much as I find them feeling they ought to have a little background because it's good on their resume. I mean, a lot of students come through here and ask me if they shouldn't go someplace where they can take an MBA -- I

mean, a --

INTERVIEWER: MPH.

DR. KOOP: -- MPH along the time they're getting their medical degree.

I always say, "Yeah, it's a great idea."

And I have actually turned a couple of people toward public health alone and forget the medical school business, because I think we need the kind of people that go into medicine to go into public health.

The other big shock to me was that I was with one of a group of six people who, about six years ago now, decided that the spread of public health from medicine was not to the benefit of either profession, and there were things that we could do together, we could fight together for principles, we could fight together for money, we could fight together for research budgets, and we could work in each other's labs and bring that together, and you know the old joke they tell about Baltimore, that the widest street in Baltimore is Wolf Street, because public health's on one side and the medical school's on the other.

But old joking aside, that group of six grew

to a group of 70, grew to a group of 240, who wanted to see public health integrated. We even got so far in the planning as to think if Dartmouth couldn't be a virtual school of public health for all the medical schools in New York and New England who didn't have a school of public health associate with a university where they were. And Roy Shores (phonetic) was very prominent in this, Stan Reiser -- do you know Reiser? He's got an interesting title, he's Professor of Humanities, the Department of Medicine, at Baylor in Houston.

And we had a meeting of the 240 invited guests, and I gave a keynote, Reiser gave a keynote, Bozher (phonetic) gave a keynote, and we went away from that meeting with the feeling, at last places like the Providence Rhode Island Department of Public Health is talking to people in Connecticut about how they can work together on problems, and terrorism wasn't even a big thought at the moment. And it is dead. It is totally dead.

And you call anybody who was part of the planning committee or something, say, "When is the next meeting?" they want to know, "What meeting?" And I

think we muffed a tremendous opportunity to bring medicine and public health together, and to stress our ways that we could cooperate. And, you know, somebody asked me one time, "If you could do something about public health and medicine, what would it be?"

And I gave an answer off the top of my head which, in retrospect, isn't too bad. I said, "The first thing I would like the people in (inaudible) in medicine to realize is that there are more doctors than medical doctors, and that they shouldn't look down their noses at people who spend their years getting a doctor in public health."

And the person who asked me the question, "Well, what about the other side?"

I said, "Ben," I said, "I think that the contribution that medicine has to make to public health in this regard is that we've got to teach all those people with MPHs that the numbers the computers spew out all the time are real honest-to-goodness people with blood, who are hurting, and they're hurting because of poverty or they're hurting because of disease or they're hurting because of both of them, or they're hurting

because our systems don't jibe right where public health interfaces with medicine." And I think it's one of the biggest challenges that we have for the future, and one of the great missed opportunities, that we can't pull together medicine and public health in such a way that we help each other instead of be detrimental to each other.

INTERVIEWER: The status of medicine. Had health care reform attempted, and you've described eloquently your role in trying to make that happen, and then as you indicated, we had a market solution that was brought upon us, managed care, which is still with us in various morphed forms.

What do you see as the lot of medicine today, and where is it headed?

DR. KOOP: Well, I think the major thing that's happened to medicine, I alluded to in reference to pediatric surgery, it's all part of the same big ball of wax, and that is the gradual evolution from a pure profession to a profession that relies on businessmen to make it work.

Take the American Medical Association. There

was a day when the infrastructure of the AMA -- that is, the people who worked out in Chicago in the AMA building -- were retired physicians or sometimes impaired physicians who couldn't do the job they did before. As those men have died and retired, they have been replaced by MBAs. They're not health-oriented, they're not medicine-oriented; they're business-oriented. And that is to the detriment of our profession.

And the second thing that I find has changed tremendously is the doctor/patient relationship. And that is, to me, the most precious thing about the practice of medicine. Medicine's appeal is not its independence financially or its ability to be your own man and your own boss, it's the fact that you interdigitate or you cooperate with the public at the interface between the patient and the doctor. And the thing that has changed that has been the things that came in with managed care, and have stayed. Even when managed care seems to have disappeared, the bad things about it stayed behind, such as 14 minutes per patient and that sort of stuff.

I ran a program with the help of John a couple

of years ago, called "Take Time to Talk." And I went around the country talking to doctors and to patients about taking time to talk with each other, and about what the benefits would be to both the profession and \_\_\_\_\_.

Secondly, we are reaching this crisis in the doctor/patient relationship just at a time when I would have predicted just the opposite, with the use of the Internet to provide information for patients, we have the opportunity to have a much more knowledgeable set of patients than their parents were. And everybody knows, I think, that a physician loves to talk to an intelligent patient, and the opportunity now exists to be able to, instead of meeting a patient and starting with a kindergarten and work him on up to college, he can ask you to do that the night before. Suppose somebody calls up and says, "I'm having pain in my chest, Doc, and I get it mostly when I'm tense or trying to be active at the same time, and I think I have an angina."

Well, the doctor doesn't say, "Well, come on in and I'll talk to you about it." He says, "I'll see

tomorrow morning, but before you come I want you to look upon the Internet the following. I want you to know what angina is, I want you to know what GERD is, I want you to know the difference between those two, and when we get here together, instead of taking 20 minutes to get to the point we are when you walk in the door tomorrow we'll have it all behind us. And I can talk about angiograms, you know what I'm talking about."

And that is not working as well as I thought it would.

The other thing that I think is a tremendous boon, and that is doctors and patients using e-mail for types of communication. We do it very well in this institution because we were the first school in America where everybody had to have a computer, and we had something called "blitzmail." And people don't use telephones in this town. They just don't use them. They use fax machines. They use e-mail. Three kids will occupy a room in a dormitory, they don't know each other very well but they know each other best by e-mail, in spite of the fact that they can reach out and touch the guy they sent an e-mail.



But the intimacy that has been lost between doctor and patient can be partially regained by the Internet, and it can be an additional boon to a patient.

Mrs. McCarthy comes in and has her time with the doctor and it turns out to be 11 minutes and she's out in the parking lot before she knows it, and she gets home and says, "I never asked him about so and so."

So she sends him an e-mail. And instead of playing telephone tag for three days, he answers her, but he has the opportunity, with no effort at all, to lift her spirits and put her on a whole different level of healing, by saying, "By the way, I should have told you, I never saw you look better." And it regains some of that intimacy that even doctors say, "I've lost with my patients."

And one of the things that I look back on, I've been in medicine now since 1934. I've been having something to do with medical students \_\_\_\_\_ 1934, and what do I look back on now and see that we've lost?

We've lost role models. Used to be that people my age were not uncommon in medical schools. They didn't want to give up, and they had an awful lot to tell students,